Business Partner Approver Certification

MC 5254 (03/13)

For Access to Confidential Mental Health Information

Business Partner: _____

To ensure the confidentiality of mental health data, the Department of Health Care Services' Information Technology Web Services (DHCS-ITWS) requests that the appropriate DHCS chief to designate a primary and a secondary contact to be responsible for approving business partner staff requests for access to confidential patient data in the systems checked below. Please complete the information below and e-mail the form to "DHCSMHSDAPPCert@dhcs.ca.gov". If you have any questions, please contact MHSD-App-Cert group via above mentioned e-mail.

Primary Approver:

First Name: _____ Last Name: _____

Title: _____

Phone Number: _____ Fax Number: _____

Email Address: _____

Primary Approver's Signature: _____
(Signer acknowledges having read Letter No. 99-02 regarding **Confidentiality of Client Information**)

Secondary Approver:

First Name: _____ Last Name: _____

Title: _____

Phone Number: _____ Fax Number: : _____

Email Address: _____

Secondary Approver's Signature: _____
(Signer acknowledges having read Letter No. 99-02 regarding **Confidentiality of Client Information**)

Mental Health Systems:

Please check the systems for which the above approvers may authorize access requests:

- ☐ **CFRS** Cost and Financial Reporting System
- ☐ **MHSA** Mental Health Services Act
- ☐ **MMEF** Monthly MEDS Extract File
- ☐ **POQI** Performance Outcome Quality Improvement (aka Consumer Perception Survey)
- ☐ **PRV/LE** Provider/Legal Entity
- ☐ **SD/MC** Short-Doyle/Medi-Cal Claims
- ☐ **SDA** Statistics and Data Analysis (aka Mental Health Analytics)

DHCS Certification:

I designate the following individuals to have independent authority to approve access requests to specific confidential mental health patient data. DHCS-ITWS may rely on approvals, denials, and changes made by these individuals in its processing of access requests to the above selected system(s). As changes occur to the above approving contact's information (name, phone, e-mail and/or system), I will sign an updated certification and forward it to "DHCSMHSDAPPCert@dhcs.ca.gov". Also, I acknowledge reading Letter No. 99-02 regarding **Confidentiality of Client Information**.

Chief or Executive Director (Signature)	Printed	Date